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We will begin shortly!

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2019 Modifier Update: Review New NCCI Guidance

A WEBINAR PRESENTED ON MAY 9, 2019

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Presented By

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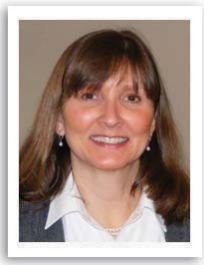

Susan E. Garrison, CHCA, CHCAS, CCS-P, CPAR, CPC, COC, is executive vice president of Healthcare Consulting Services at Med Law Advisors in Atlanta. Garrison has more than 25 years of experience in healthcare management, including documentation, coding, billing, and reimbursement for both outpatient hospital and physician services. She has conducted hundreds of engagements at hospitals across the country to improve hospital and physician compliance and reimbursement.

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Describe the latest NCCI guidance and where to locate it
  - Apply modifiers to override PTP edits, including how to bypass column-one/column-two code edit pairs effective July 1, 2019
  - Appropriately apply modifiers LT, RT, and 50, plus other anatomic modifiers
  - Ensure documentation supports modifier 25, 58, and 59 usage as well as other NCCI modifiers
  - Differentiate between modifiers 25 and 27
  - Understand the rationale behind a few modifiers that were added for 2019

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Disclaimer

- Every reasonable effort has been taken to ensure that the educational information provided in today's presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation.

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Agenda

- Chapter 1: Correct Coding Policies
  - Overview of PTP edits and MUEs
  - General guidance for assigning NCCI-associated modifiers
- Chapters 3–8: Surgical Services
  - Examples of how to apply modifiers LT, RT, 50, and other anatomic modifiers
  - Appropriate application of modifier 58 in the outpatient setting
- Chapters 9 and 10: Radiology and Laboratory Services
  - Modifiers commonly reported with CPT® codes for radiology and laboratory services
  - New guidance for reporting laboratory panels and repeat testing
- Chapter 11: E/M and Medicine Services
  - Clinical scenarios for reporting visit modifiers 25 and 27
  - Correct use of modifier 76 for inhalation treatments
  - Special considerations for drug administration services
- New HCPCS modifiers for 2019
  - Proper application of modifiers ER, G0, CO, and more
- Live Q&A

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National Correct Coding Initiative (NCCI)

Overview and Chapter 1

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NCCI Defined

- The National Correct Coding Initiative (NCCI) drives bundling edits:
  - The NCCI was developed by CMS to prevent inappropriate payment of services when incorrect code combinations are reported (i.e., codes that should not be billed by the same provider for the same patient on the same date of service)
  - NCCI edits are used by Medicare carriers and other payers in adjudicating claims
  - Information about the edits can be found on the CMS website at the following link:

    https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/01_overview.asp#TopOfPage

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NCCI Defined (cont.)

- NCCI Toolkit
  - CMS has published a very helpful guide to assist in navigating and understanding the Medicare NCCI tools

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf

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NCCI Defined (cont.)

- There are three types of NCCI edits:
  - Procedure-to-procedure (PTP) edits
  - Medically unlikely edits (MUEs)
  - Add-on code edits *(since 2013)*
- The latest version of each edit file is available on the CMS website:
  - Quarterly changes to PTP edits and MUEs are posted on a separate "Quarterly NCCI and MUE Version Update Changes" page
  - Quarterly changes for add-on code edits are on the home page for add-on code edits
- New version of the *NCCI Manual* was published effective January 1, 2019, which:
  - Contains added text to most sections (in *red italicized font*) for new or updated coding guidance for particular services
  - Can be downloaded from: *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/*

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PTP Edits

- Procedure-to-procedure (PTP) edits
  - These prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column-one code is eligible for payment but the column-two code is denied unless a clinically appropriate NCCI-associated modifier is also reported.* Here is an example from the April 1, 2019 Hospital PTP file:

G0463	92012	20140701	*	1	More extensive procedure
G0463	92014	20140701	*	1	More extensive procedure
G0463	92227	20140701	*	1	CPT Manual or CMS manual coding instructions
G0463	92228	20140701	*	1	CPT Manual or CMS manual coding instructions
G0463	93792	20180101	*	1	Misuse of column two code with column one code
G0463	93793	20180101	*	1	Misuse of column two code with column one code
G0463	94002	20140701	*	0	CPT Manual or CMS manual coding instructions
G0463	94003	20140701	*	0	CPT Manual or CMS manual coding instructions
G0463	94004	20140701	*	0	CPT Manual or CMS manual coding instructions
G0463	95831	20140701	*	1	Standards of medical / surgical practice

** See next slide*

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PTP Edits – New Info for 2019

- Note: Effective July 1, 2019 and after, CMS will allow modifier 59 *(distinct procedural service)* and its subset of X{EPSU} modifiers to be appended to both the column-one and column-two codes in the National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits. Until then, an appropriate NCCI modifier may be appended only to the column-two code to bypass the edit.
- To read more, go to:

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R2259OTN.pdf

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PTP Edits

- Each PTP edit has one of the following assigned modifier indicators:
  - "0" which means that under no circumstances may a modifier be used
  - "1" which means an appropriate NCCI-associated modifier may apply
  - "9" which denotes that the code pair's edit has been deleted and is therefore irrelevant
- The latest 2019 PTP edits can be downloaded from the CMS website at:

  https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

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NCCI PTP Modifiers

- According to CMS, there are 44 modifiers that can be used, when appropriate, to bypass PTP bundling guidelines. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.
- The NCCI PTP bypass modifiers include:

```
Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT,
LC, LD, RC, LM, RI
Global surgery modifiers: 24, 25, 57, 58, 78, 79
Other modifiers: 27, 59, 91, XE, XS, XP, XU
```

- Modifier 59 is always on the list even though it is the modifier of "last resort."

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI-Policy-January-1-2019.zip

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Add-On Code Edits

- Add-on code edits
  - These are codes that describe a service that, with one exception (i.e., if two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service), is always performed in conjunction with another primary service. Beyond this exception, an add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner and is never eligible for payment if it is the only procedure reported by a practitioner.
  - Listings of such HCPCS add-on codes with their respective primary codes may be found in CMS *Transmittal 2636,* CR 7501, and on the CMS website at:

    https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html

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Add-On Code Edits (cont.)

- Add-on code edits
  - Add-on codes may be identified in three ways:
    - The code is listed in CMS Change Request (CR) 7501 (or subsequent ones) as a Type I, Type II, or Type III add-on code
    - The add-on code generally has a global surgery period of "ZZZ" on the Medicare Physician Fee Schedule (MPFS) database
    - The add-on code is designated by the symbol "+" and often accompanied by a parenthetical note as well

TYPE I - CPT MANUAL, HCPCS MANUAL, AND/OR CMS POLICY DEFINES ALL ACCEPTABLE PRIMARY CODES			
ADD-ON CODE	PRIMARY CODE(S)	Effective Date	Deletion Date
10004	10021	1/1/2019	
10006	10005	1/1/2019	
10008	10007	1/1/2019	
10010	10009	1/1/2019	
10012	10011	1/1/2019	
10036	10035	1/1/2016	
11001	11000	4/1/2013	
11008	10180, 11004-11006	4/1/2013	
11045	11042	4/1/2013	
11046	11043	4/1/2013	
11047	11044	4/1/2013	
11101	11100	4/1/2013	12/31/2018

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MUEs

- MUEs indicate the maximum units of service reportable under *most* circumstances for a single patient on a single date of service.
- Not all CPT/HCPCS codes have an MUE.
- *Most* MUEs are on the CMS website, *but there are other MUE limitations that are not publicized.* The confidential values are not to be shared outside the CMS contractor's organization.
- The latest 2019 MUEs can be downloaded from the CMS website at:
  https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

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MUEs (cont.)

- MUE values are based on:
  - Anatomic considerations *(e.g., appendix)*
  - HCPCS code description *(e.g., initial hour)*
  - CMS policy *(e.g., bilateral surgery indicator)*
  - Nature of the equipment *(e.g., wheelchair)*
  - Nature of the analyte *(e.g., 24-hour urine collection)*
  - Nature of the procedure *(e.g., overnight sleep study)*
  - Clinical judgment of physicians and coders
  - Prior submitted claims data

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MUE Adjudication Indicators

- MUE Adjudication Indicators (MAIs) identify the type of and rationale for the MUE. They let providers know whether the MUE is a claim-line edit or a date-of-service edit based on policy or clinical benchmarks. Each of the MAIs has a different rationale. Check with your Medicare Administrative Contractor (MAC) for additional guidance as to when it is appropriate to bypass an edit.

  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8853.pdf

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MUE Adjudication Indicators (cont.)

- There are 3 types of MAIs:
  - MUEs for HCPCS codes with a MAI of "1":
    - Continue to be adjudicated as a claim line edit.
  - MUEs for HCPCS codes with a MAI of "2":
    - Are absolute date-of-service edits, i.e., "per day edits based on policy."
    - Have been rigorously reviewed and vetted within CMS and obtain this MAI designation because units of service on the same date of service in excess of the MUE value would be considered impossible due to being contrary to statute, regulation, or sub-regulatory guidance.
  - MUEs for HCPCS codes with a MAI of "3":
    - Are date-of-service edits based on "clinical benchmarks."
    - May be paid upon appeal with adequate documentation of medical necessity of correctly reported units.

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MUE Modifiers

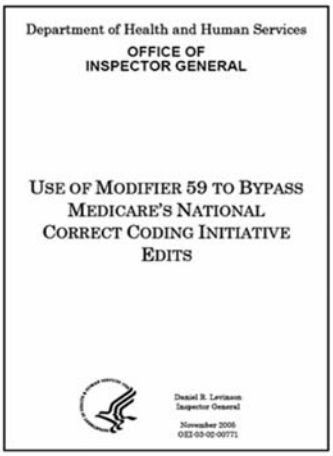
- The *2019 NCCI Policy Manual* provides guidance on the appropriate use of modifiers for MUEs. Note that modifiers 76 and 77 can be used to bypass MUE edits but not PTP ones:

> If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, appropriate use of CPT modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes.

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI-Policy-January-1-2019.zip

NCCI Modifiers

- When using modifiers to override NCCI PTP, MUE, or add-on code edits, remember:
  - Be wary of using modifiers simply for bypassing edits—always go back to the documentation
  - Responsibility for appending varies significantly from hospital to hospital
  - There has been so much misuse and confusion regarding modifier 59 that the OIG has published guidance on its use


Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

USE OF MODIFIER 59 TO BYPASS MEDICARE'S NATIONAL CORRECT CODING INITIATIVE EDITS

Daniel R. Levinson
Inspector General

November 2008
OEI-03-02-00771

http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf

NCCI Manual 2019 Updates – Chapter 1

- Chapter 1: General Correct Coding Policies
  - New instructions on bilateral procedures:

> Many surgical procedures may be performed bilaterally. Instructions in the CMS *Internet-only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 require that bilateral surgical procedures be reported using modifier 50 with one unit of service *unless the code descriptor defines the procedure as "bilateral". If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with one unit of service without modifier 50.* If a bilateral surgical procedure is performed at different sites bilaterally, one unit of service may be reported for each site. That is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

  - Updated guidance on requesting reconsideration of MUE values:

> A provider, supplier, healthcare organization, or other interested party may request reconsideration of an MUE value for a HCPCS/CPT code *by CMS by writing the NCCI/MUE contractor.* Written requests proposing an alternative MUE with rationale may be sent to the entity and address identified on the CMS NCCI website (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

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NCCI Manual 2019 Updates – Chapter 1 (cont.)

- Chapter 1: General Correct Coding Policies
  - Change from "may" to "should" regarding lab panels and reference to Chapter 10, which will be covered in more detail later:

N. Laboratory Panel

The *CPT Manual* defines organ and disease specific panels of laboratory tests. If a laboratory performs all tests included in one of these panels, the laboratory *should* report the CPT code for the panel. If the laboratory repeats one of these component tests as a medically reasonable and necessary service on the same date of service, the CPT code corresponding to the repeat laboratory test may be reported with modifier 91 appended *(See Chapter X, Section C (Organ or Disease Oriented Panels).)*

  - Clarification on biopsies if done in conjunction with another, more extensive procedure:

The biopsy is not separately reportable if *utilized* for the purpose of assessing margins of resection or verifying resectability.

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National Correct Coding Initiative (NCCI)

Chapters 3–8

Integumentary NCCI Policy Manual Excerpt

- I&D:
  - Same site/same session—don't code

D. Incision and Drainage

Incision and drainage services, as related to the integumentary system, generally involve cutaneous or subcutaneous drainage of cysts, pustules, infections, hematomas, abscesses, seromas or fluid collections.

If it is necessary to incise and/or drain a lesion as part of another procedure or in order to gain access to an area for another procedure, the incision and/or drainage is not separately reportable if performed at the same patient encounter.

For example, a physician excising pilonidal cysts and/or sinuses (CPT codes 11770-11772) may incise and drain one or more of the cysts. It is inappropriate to report CPT codes 10080 or 10081 separately for the incision and drainage of the pilonidal cyst(s).

HCPCS/CPT codes for incision and drainage shall not be reported separately with other procedures such as excision, repair, destruction, removal, etc., when performed at the same anatomic site at the same patient encounter.

HCPCS/CPT codes describing complications of a procedure may or may not be separately reportable at the same patient encounter as the procedure causing the complication. (See Chapter I, Section C, Subsection #14)

CPT code 10180 (incision and drainage, complex, postoperative wound infection) would never be reportable for the same patient encounter as the procedure causing the postoperative infection. It may be separately reportable with a subsequent procedure depending upon the circumstances. If it is performed to gain access to an anatomic region for another procedure, CPT code 10180 is not separately reportable. However, if the procedure described by CPT code 10180 is performed at an anatomic site unrelated to another procedure, it may be reported separately with the procedure.

Integumentary NCCI Policy Manual Excerpt

I&D:

What would you do?

- Patient is a 40-year-old female who presents complaining of a swollen tender area in her abdominal wall. States it is draining fluid. No fevers. She has had previous hernia surgery repair in the same area.
- In the left mid to lower abdomen there is an area of skin abscess which is draining a small amount of fluid. When this area of drainage is extended to allow for complete drainage we can visualize a suture material consistent with a subcutaneous stitch. This stitch is cut and removed by this examiner during exam. Patient tolerated procedure well.

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Incision and Drainage Analysis

I&D:

- Option 1: CPT 10060 (I&D of abscess—simple or single) and
  CPT 10120 (Incision & removal foreign body, subcutaneous tissues simple)

Or

- Option 2: CPT 10120 only

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Incision and Drainage Analysis (cont.)

- They do ***not*** bundle:

5	10040	G0471		20150701	*	1	Standards of medical / surgical practice
6	10060	0213T		20100701	*	1	Misuse of column two code with column one co
7	10060	0216T		20100701	*	1	Anesthesia service included in surgical procedure
8	10060	0228T		20101001	*	1	Anesthesia service included in surgical procedure
9	10060	0230T		20101001	*	1	Anesthesia service included in surgical procedure
10	10060	11055		19990401	*	1	More extensive procedure
11	10060	11056		19990701	*	1	Standards of medical / surgical practice
12	10060	11057		19990401	*	1	Standards of medical / surgical practice
13	10060	11401		19960101	*	1	Mutually exclusive procedures
14	10060	11402		19960101	*	1	Mutually exclusive procedures

10081	G0471		20150701	*	1	Standards of medical / surgical practice
10120	0213T		20100701	*	1	Misuse of column two code with column one code
10120	0216T		20100701	*	1	Misuse of column two code with column one code
10120	0228T		20101001	*	1	Standards of medical / surgical practice
10120	0230T		20101001	*	1	Standards of medical / surgical practice
10120	11000		20161001	*	1	Misuse of column two code with column one code

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Incision and Drainage Analysis (cont.)

- This is a pretty simple one—obviously since this is at the same site, only CPT 10060 should be billed
- However, what trips some folks up is that these two codes do not bundle—regardless, it would still be wrong to code both based on NCCI guidance.
- Extra tip: Just because something doesn't bundle and you don't need a modifier, it doesn't mean you can code both.

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Musculoskeletal NCCI Policy Manual Excerpt

- Arthroscopy:
- Shoulder = 1 joint
- Do not bypass edits for limited debridement—regardless of shoulder area
- Do not bypass edits UNLESS for extensive debridement with:
  - Rotator cuff repair (29827)
  - Biceps tenodesis (29828)
  - Claviculectomy (29824)

  &

- In a different area of the shoulder

4. CMS considers the shoulder to be a single anatomic structure. With three exceptions an NCCI procedure-to-procedure edit code pair consisting of two codes describing two shoulder arthroscopy procedures shall *not* be bypassed with an NCCI-associated modifier when the two procedures are performed on the ipsilateral shoulder. This type of edit may be bypassed with an NCCI-associated modifier only if the two procedures are performed on contralateral shoulders. The three exceptions are described in Chapter IV, Section E (Arthroscopy), Subsection #7.

7. Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure. With three exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder than the other procedure. CPT codes 29824 (arthroscopic claviculectomy including distal articular surface), 29827 (arthroscopic rotator cuff repair), and 29828 (biceps tenodesis) may be reported separately with CPT code 29823 if the extensive debridement is performed in a different area of the same shoulder.

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Musculoskeletal Example

- DIAGNOSTIC ARTHROSCOPY AND EXTENSIVE DEBRIDEMENT: A standard posterolateral arthroscopic portal was made 2 cm medial and inferior to the posterolateral border of the acromion. The arthroscope was introduced into the glenohumeral joint. Under direct visualization, an anterior portal was made in the rotator interval. A diagnostic arthroscopy was performed. There was extensive synovitis in the subcoracoid recess and in the recess superior to the glenoid labrum. This was debrided using a 4.5 mm shaver and ArthroCare device.
- SUBACROMIAL DECOMPRESSION WITH PARTIAL ACROMIOPLASTY: Next, the arthroscope was introduced into the subacromial space. An extensive bursectomy and synovectomy was performed in the subacromial space using a combination of 4.5 mm shaver and the ArthroCare device. There was a large acromial spur; therefore, a standard anterolateral portal was made and a 4.5 mm shaver was used on bur mode to perform a partial acromioplasty.
- SUBCORACOID DECOMPRESSION: There was extensive synovitis in the region between the subscapularis tendon and the coracoid. This was debrided using a combination of 4.5 mm shaver and ArthroCare device. The inferior surface of the coracoid was exposed. The interval between the coracoid and subscapularis was greater than 8 mm; therefore, partial coracoidplasty was not performed.

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Musculoskeletal Analysis

I&D:

- Option 1: CPT 29823 (Arthroscopy, shoulder, extensive debridement) and CPT 29826 (Arthroscopy, shoulder, surgical decompression)

Or

- Option 2: CPT 29826 or 29823 only?

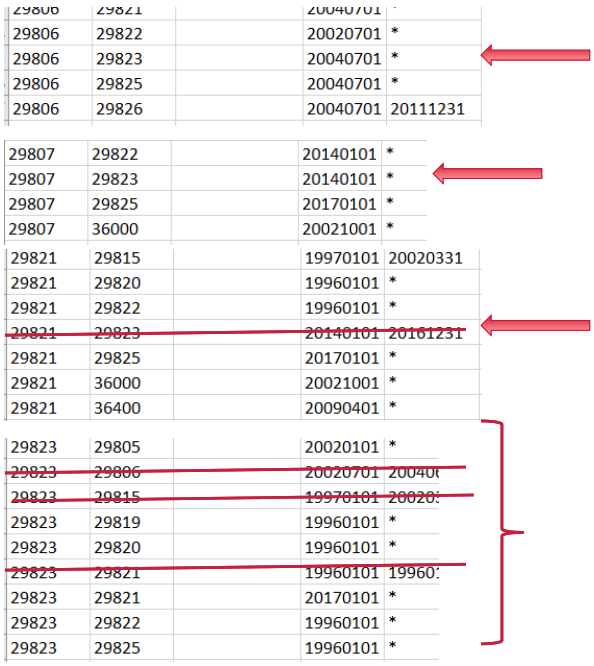
These codes do not bundle.

Musculoskeletal Analysis (cont.)

- Note with careful reading of the guidelines, it states when codes bundle, don't bypass them unless …
- In this case, the codes do not bundle, so both may be coded without a problem
- Also, CPT 29826 is an add-on code billable with CPT 29823 as the base code

Musculoskeletal Analysis (cont.)

- Some bundling edits for CPT 29813
- Cannot bypass regardless of shoulder area



29806	29822		20020701	*
29806	29823		20040701	*
29806	29825		20040701	*
29806	29826		20040701	20111231
29807	29822		20140101	*
29807	29823		20140101	*
29807	29825		20170101	*
29807	36000		20021001	*
29821	29815		19970101	20020331
29821	29820		19960101	*
29821	29822		19960101	*
29821	29823		20140101	20161231
29821	29825		20170101	*
29821	36000		20021001	*
29821	36400		20090401	*
29823	29805		20020101	*
29823	29806		20020701	20040
29823	29815		19970101	20020
29823	29819		19960101	*
29823	29820		19960101	*
29823	29821		19960101	19960
29823	29821		20170101	*
29823	29822		19960101	*
29823	29825		19960101	*

Digestive NCCI Policy Manual Excerpt

Hernias:

- Do not code if at incision site of other procedure

4. If a hernia repair is performed at the site of an incision for an open or laparoscopic abdominal procedure, the hernia repair (e.g., CPT codes 49560-49566, 49652-49657) is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and shall not be reported separately.

Hernia Example

- Attention was turned to the abdomen. Two clamps were placed peri-umbilically and the abdomen was tented. A needle was inserted into Palmer's point and CO2 gas was connected to allow for an adequate pneumoperitoneum. A port was entered into Palmer's point under direct visualization. A large umbilical hernia was noted. An incision was then made about 4-5 cm superior to the umbilicus, being careful to avoid the hernia site. Trocar was then inserted into this site. Initial inspection revealed no signs of trauma and no evidence of bleeding. Robotic accessory ports were placed in into the left and right lower quadrants, and 11 mm bladeless ports were placed into the left and right upper quadrants. All ports were placed under direct visualization.
- It became evident that the hernia would need to be removed from the abdominal wall for proper examination of the pelvis. Using the forceps and cautery, the hernia was removed from the abdominal wall. Hemostasis was noted to be achieved.

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Hernia Example (cont.)

- The round ligaments were then grasped bilaterally, fulgurated w/forceps and cut w/monopolar cautery. The peritoneum was then extended superiorly on both sides. The IP ligaments were then skeletonized bilaterally. The ureters were then identified deep within the retroperitoneum on both sides. The bilateral IP ligaments were then cauterized w/forceps and divided with robotic scissors. Hemostasis was noted to be excellent.
- A bladder flap was then created using a combination of monopolar cautery and sharp dissection. The peritoneum was then taken down posteriorly to the level of the KOH ring bilaterally. The uterine arteries were then skeletonized bilaterally. The ureters were then identified bilaterally and noted to be well lateral to the uterine vessels. The uterine vessels were then grasped w/forceps and coagulated. They were then cut w/scissors. Hemostasis was noted to be excellent. Anterior and posterior colpotomies were then performed w/monopolar cautery. The cardinal ligaments and uterosacral ligaments were serially grasped w/forceps, fulgurated, and cut using scissors.

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Hernia Example (cont.)

- The uterus was then delivered through the vagina. The vaginal cuff was then reapproximated at the angles using a 0-vicryl suture. The remainder of the cuff was reapproximated using a 0-Stratafix suture in a running fashion. The pelvis was irrigated. There was no bleeding noted. Ureters were re-identified bilaterally and noted to be without evidence of hydroureter. Surgicel® was then placed across the vaginal cuff.
- The site where the hernia was removed was again reexamined. Due to concern for possible reincarceration of hernia, chose to close the peritoneum with interrupted 2-0 Silk suture. This was performed without difficulty. Hemostasis was noted.
- The daVinci surgical system was then undocked. Pneumoperitoneum was released, trocars were removed. The incisions were re-approximated w/ 4-0 monocryl suture and the skin was reapproximated using dermabond.

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Hernia Analysis

- Do we code the hernia repair?
- No; however, this is a toughie—but the repair appears to be made for visualization to the pelvis for the primary procedure and was discovered at the site of incision.

HCPro

Other NCCI Surgery Guidance

Integumentary

- Here's a coding tip on correct coding of adjacent tissue transfers (ATT)
- Note: To code ATT, it must be the physician's intention to make an adjacent transfer and not to simply close the wound

4. Adjacent tissue transfer codes shall not be reported with the closure of a traumatic wound if the laceration is coincidentally approximated using a tissue transfer type closure (e.g., Z-plasty, W-plasty). The closure should be reported with repair codes. However, if the surgeon develops a specific tissue transfer to close a traumatic wound, a tissue transfer code may be reported.

HCPro

Other NCCI Surgery Guidance

Breast

- A bit tricky, but just think of the excision (or biopsy) where the frozen section is performed and the decision for mastectomy is made; code both
- Modifier 58 gets a bit tricky here because it is to be attached to the 2nd procedure—make sure A/R checks payment
- If the pathology is being performed after the more extensive service, do not code the biopsy

J. Breast (Incision, Excision, Introduction, Repair and Reconstruction)

1. Since a mastectomy (CPT codes 19300-19307) describes removal of breast tissue including all lesions within the breast tissue, breast excision codes (19110-19126) generally are not separately reportable unless performed at a site unrelated to the mastectomy. However, if the breast excision procedure precedes the mastectomy for the purpose of obtaining tissue for pathologic examination which determines the need for the mastectomy, the breast excision and mastectomy codes are separately reportable. (Modifier 58 may be utilized to indicate that the procedures were staged.) If a diagnosis was established preoperatively, an excision procedure for the purpose of obtaining additional pathologic material is not separately reportable.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

HCPro

Other NCCI Surgery Guidance

Musculoskeletal

- If arthroscopy is just to get a lay of the land but an open procedure is the truly planned procedure, do not code the arthroscopy
- If the arthroscopy is truly diagnostic, and the decision to perform the open procedure is made based on the scope, it's OK to code both (modifier 58 vs. 59)
- However, if there is a diagnostic scope then an attempted treatment scope that fails and is converted into an open procedure, only the open procedure can be coded (it might seem as if you should be able to get the diagnostic scope, but you can't)

2. If an arthroscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic arthroscopy lead to the decision to perform an open procedure, the diagnostic arthroscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic arthroscopy and non-arthroscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic arthroscopy.

3. If an arthroscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical arthroscopy nor a diagnostic arthroscopy code shall be reported with the open procedure code when a surgical arthroscopic procedure is converted to an open procedure.

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Other NCCI Surgery Guidance

Musculoskeletal (cont.)

- What is needed before coding the synovectomy:
  - Only the synovectomy is performed or
  - Synovectomy is in at least 2 compartments that are separate from the therapeutic procedure(s)

8. Arthroscopic synovectomy of the knee may be reported with CPT codes 29875 (limited synovectomy, "separate procedure") or 29876 (major synovectomy of two or three compartments). A synovectomy to "clean up" a joint on which another more extensive procedure is performed is not separately reportable. CPT code 29875 shall *not* be reported with another arthroscopic knee procedure on the ipsilateral knee. CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in two compartments on which another arthroscopic procedure is not performed. For example, CPT code 29876 shall *not* be reported for a major synovectomy with CPT code 29880 (knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee since knee arthroscopic procedures other than synovectomy are performed in two of the three knee compartments.

HCPro

Other NCCI Surgery Guidance

Musculoskeletal (cont.)

- Follow-up doesn't apply to outpatient hospitals (unless on same day as primary procedure).
- Treatment of fracture without definitive px (just the cast, splint, or strap) must use the cast/splint/strap CPT codes.
- What if the definitive treatment is non-reduced casting?

7. If a physician treats a fracture, dislocation, or injury with an initial cast, strap, or splint and also assumes the follow-up care, the physician cannot report the casting/splinting/strapping CPT codes since these services are included in the fracture and/or dislocation CPT codes.

8. If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the physician may report an evaluation and management (E&M) service, a casting/splinting/ strapping CPT code, and a cast/splint/strap supply code (Q4001–Q4051).

For OPPS if a hospital treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment, the hospital should report the appropriate casting/splinting/strapping CPT code. Payment for the cast/splint/strap supplies is included in the payment for the procedure reported.

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Other NCCI Surgery Guidance

Respiratory

- Really the same guideline that we discussed in Breast—if the decision for more extensive surgery was made (truly) based on the biopsy, both may be coded
- Remember, that means a path result must be obtained before the decision for more extensive surgery

2. A biopsy performed in conjunction with a more extensive nasal/sinus procedure is not separately reportable unless the biopsy is examined pathologically prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination.

Example: If a patient presents with nasal obstruction, sinus obstruction and multiple nasal polyps, it may be reasonable to perform a biopsy prior to, or in conjunction with, polypectomy and ethmoidectomy. A separate biopsy code (e.g., CPT code 31237 for nasal/sinus endoscopy) shall not be reported with the removal nasal/sinus endoscopy code (e.g., CPT code 31255) because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

HCPro

Other NCCI Surgery Guidance

Cardiovascular

- Just to repeat CPT directives:
  - You may bill a diagnostic angiography in addition to therapeutic procedures when:
    - It is truly diagnostic
    - The therapeutic procedure does not already include the diagnostic angiography

13. Open and percutaneous interventional vascular procedures include operative angiograms and/or venograms which shall not be separately reported as diagnostic angiograms/venograms. The *CPT Manual* describes the circumstances under which a provider may separately report a diagnostic angiogram/venogram at the time of an interventional vascular procedure. A diagnostic angiogram/venogram may be separately reportable with modifier 59 if it satisfies *CPT Manual* guidelines, national Medicare guidelines, and local Medicare Administrative Contractor guidelines. If the code descriptor for a vascular procedure specifically includes diagnostic angiography, the provider shall not separately report a diagnostic angiography code.

If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the open or percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the open or percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier 59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier 52 in addition to modifier 59 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider shall not report a second angiogram for the dye injections necessary to perform the open or percutaneous intravascular interventional procedure.

HCPro

Other NCCI Surgery Guidance

- There are specific times when a repeat diagnostic angiography at the same session of intervention may be reportable:
  - The interval between the original diagnostic study and the actual intervention is unusually long and disease progression could occur and the pathology/anatomy may be changed.
  - The initial diagnosis was incomplete, and not clearly documented. This might be when modifier -52 would be useful.
  - A clinical change occurs between the time of the diagnosis and the treatment.
  - Imaging at the time of treatment shows significant differences from the original diagnosis, necessitating repeat imaging.
  - A significant clinical change occurs during the treatment procedure necessitating a repeat of the diagnostic study.

HCPro

Other NCCI Surgery Guidance

Cardiovascular

- Pretty straightforward, but remember, the x-ray is for a diagnostic purpose (not for position confirmation or pneumothorax); both are okay to bill

37. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. The chest radiologic examination is integral to the procedure, and a chest radiologic examination (e.g., CPT codes 71045, 71046) shall not be reported separately.

HCPro

Other NCCI Surgery Guidance

Digestive

- Again, pretty obvious, but since they are different body systems, this is an important note:
  - Different scopes
  - Rationale for both

15. If the larynx is viewed through an esophagoscope or upper gastrointestinal endoscope during endoscopy, a laryngoscopy CPT code cannot be reported separately. However, if a medically necessary laryngoscopy is performed with a separate laryngoscope, both the laryngoscopy and esophagoscopy (or upper gastro-intestinal endoscopy) CPT codes may be reported with NCCI-associated modifiers.

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Other NCCI Surgery Guidance

Digestive (cont.)

- Hospitals don't have the option of modifier 22, so what should we do to capture extensive lysis of adhesions?
- It depends on the payer, but a thought:
  - Code unlisted and submit this excerpt plus the record and recommend the 44005/44180 as comparable codes

9. Open enterolysis (CPT code 44005) and laparoscopic enterolysis (CPT code 44180) are defined by the *CPT Manual* as "separate procedures". They are not separately reportable with other intra-abdominal or pelvic procedures. However, if a provider performs an extensive and time-consuming enterolysis in conjunction with another intra-abdominal or pelvic procedure, the provider may append modifier 22 to the CPT code describing the latter procedure. The local carrier (A/B MAC processing practitioner service claims) will determine whether additional payment is appropriate.

Other NCCI Surgery Guidance

Nervous

- Just make sure you choose the right code; do not code the "without imaging guidance" and then add the image code.

21. CPT codes 62310-62319 describe injections of diagnostic or therapeutic substance(s) into the epidural or subarachnoid spaces at different spinal levels. Fluoroscopic guidance such as CPT code 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid))is included in these procedures and should not be reported separately with these codes.

On January 1, 2017, CPT codes 62310-62319 were replaced by CPT codes 62320-62327. CPT codes 62321, 62323, 62325, and 62327 describe these injections with fluoroscopic or CT guidance, and CPT codes 62320, 62322, 62324, and 62326 describe these injections without imaging guidance.

National Correct Coding Initiative (NCCI)

Chapters 9 and 10

HCPro

NCCI Radiology Modifiers

- Modifiers LT/RT/50
  - While there are a number of anatomical and laterality modifiers, a few of the most common are LT (left side), RT (right side), and 50 (bilateral procedure; procedures/services that occur on identical, opposing structures)
  - Applicable to surgical and imaging services
  - Can report one line appending modifier 50 with one unit of service, or in lieu of the 50 modifier, report the RT and LT modifiers as follows:
    - One line with both RT and LT using two units of service
    - Two lines using RT and LT with one unit of service on each line

https://www.cgsmedicare.com/partb/pubs/news/2013/0813/cope22855.html

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NCCI Radiology Modifiers (cont.)

- Modifier GG
  - Defined as "Performance of a screening mammography and diagnostic mammography on the same patient on the same day"
  - Guidelines/instructions:
    - Medicare allows additional mammogram films to be performed without an additional order from the treating physician
    - When the radiologist's interpretation of screening mammography results in the performance of diagnostic mammography on the same day for the same patient, both tests will be reimbursed
    - For tracking and data collection purposes but does not impact payment
    - Can be reported in conjunction with a laterality modifier

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NCCI Manual 2019 Updates – Chapter 9

- Chapter 9: Radiology Services
  - Updated guidance for deleted fluoroscopy code:

8. Fluoroscopy reported as CPT code 76000 is integral to many procedures including, but not limited, to most spinal, endoscopic, and injection procedures and shall not be reported separately. For some of these procedures, there are separate fluoroscopic guidance codes which may be reported separately. *(CPT code 76001 was deleted January 1, 2019.)*

Radiological guidance procedures include all radiological services necessary to complete the procedure. CPT codes for fluoroscopy (e.g., 76000) shall not be reported separately with a fluoroscopic guidance procedure. CPT codes for ultrasound (e.g., 76998) shall not be reported separately with an ultrasound guidance procedure. A limited or localized follow-up computed tomography study (CPT code 76380) shall not be reported separately with a computed tomography guidance procedure. *(CPT code 76001 was deleted January 1, 2019.)*

  - Updated guidance on requesting reconsideration of MUE values:

service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the *NCCI*/MUE contractor. *Written requests for reconsideration of an MUE may be sent to the entity and address identified on the CMS NCCI website (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).*

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NCCI Laboratory Modifiers

- Modifier 91
  - Is for "repeat *clinical diagnostic* laboratory procedures" paid under the CLFS. Note that each service repeated must be medically necessary (i.e., by physician order) to obtain subsequent reportable test values. For panel testing, NCCI contains edits pairing each panel code (column-one code) with the corresponding individual laboratory tests that are included in the panel (column-two code).
  - Should not be used:
    - For poor specimen collection or to validate original results
    - For stat results when the original has not yet been received
    - If another code can be used to capture all the services (e.g., GTT)
  - Must be supported by documentation indicating that it was distinct or separate from other lab services on the same date of service.

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NCCI Laboratory Modifiers (cont.)

- Modifier 91 vs. 59
  - *CPT Assistant*, June 2002, clarified when modifier 59 vs. 91 should be used. Basically, modifier 59 should be reported when different "types" of specimens are obtained and can be used if the tests are run simultaneously, concurrently, or in separate sessions on the same date in order to obtain multiple results. So "different types of specimens" is the key phrase here.
  - Modifier 91 would be used when the physician specifically wants to repeat the same lab test and same specimen type at a later time on the same date to see if the result is different.

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NCCI Manual 2019 Updates – Chapter 10

- Chapter 10: Pathology/Laboratory Services
  - Clarification of multiple test results:

> *If a laboratory procedure produces multiple reportable test results, only a single HCPCS/CPT code shall be reported for the procedure. If there is no HCPCS/CPT code that describes the procedure, the laboratory shall report a miscellaneous or unlisted procedure code with a single unit of service.*

  - Reporting organ- or disease-oriented panels:

> The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of groups of specified tests. If all tests of a CPT defined panel are performed, the provider *should* bill the panel code. The panel codes *should* be used when the tests are ordered as that panel. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service *should* be reported as a lipid panel (CPT code 80061) *(See Chapter I, Section N (Laboratory Panel).)*

  - Limitations on definitive drug testing:

> Beginning January 1, 2016, definitive *drug* testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. *On January 1, 2017, HCPCS code G0659 defining a different type of definitive drug testing was added.* Only one code from this *group of* codes may be reported per date of service.

NCCI Manual 2019 Updates – Chapter 10 (cont.)

- Chapter 10: Pathology/Laboratory Services
  - Use of unlisted code for molecular pathology:

> 8. If one laboratory procedure evaluates multiple genes utilizing a next generation sequencing procedure, the laboratory shall report only one unit of service of one genomic sequencing procedure, molecular multianalyte assay, multianalyte assay with algorithmic analysis, or proprietary laboratory analysis CPT code. If no CPT code accurately describes the procedure performed, the laboratory shall report CPT code 81479 (unlisted molecular pathology procedure) with one unit of service. The laboratory shall not report multiple individual CPT codes describing the component test results. If a single procedure is performed, only one HCPCS/CPT code with one unit of service may be reported for the procedure.

  - Updates to immunology allergen testing:

> **I. Immunology**
>
> 1. Allergen specific IgE testing may be performed using crude allergen extracts (CPT code 86003) or recombinant or purified components (CPT code 86008). Both procedures may be reported for the same date of service if the two types of testing are performed for different allergens. Both procedures may also be reported for the same date of service if allergen specific IgE crude extract testing is positive and allergen specific IgE component testing for that crude allergen is ordered by the treating physician and is utilized for management of the patient's specific medical problem. The laboratory shall not routinely perform allergen specific IgE component testing when the allergen specific IgE crude allergen extract test is positive.

National Correct Coding Initiative (NCCI)

Chapter 11

HCPro

NCCI E/M Modifiers

- Modifier 25
  - May be used to indicate a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service."
    - Note that the same physician/practitioner does not have to conduct the procedure and the E/M service in order for modifier 25 to apply in the facility setting. What is important is that the same facility provided the procedure and the E/M service.
  - Should be used in conjunction with:
    - E/M service codes including G0463, which replaced codes 99201–99205 (new visit) and 99211–99215 (established visit) in 2014, the ED E/M codes 99281–99285, and critical care (99291).
    - Procedure codes having a payment status indicator of "S" or "T" under the outpatient prospective payment system (OPPS) to avoid triggering an Outpatient Code Editor (OCE) edit.

Remember: Modifier 25 is appended to the E/M code, not the procedure.

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NCCI Modifier -25 Case Scenarios

- Patient is seen in the ED after a fall with shoulder pain. X-rays are performed.
  - Can we bill E/M with modifier 25 in addition to x-rays?
    - Answer: Yes, an E/M service would generally be medically necessary in this instance to assess for other injuries related to the fall
- Patient presents to outpatient clinic for scheduled wound care. Wound care nurse assesses current state of wound and begins CPT 97597 (debridement).
  - Would the facility bill an E/M code in addition to the wound care?
  - If so, would modifier 25 apply?
    - Answer: No, an E/M would not be appropriate unless unforeseen circumstances arise or patient presents with new wounds/health issues requiring assessment

NCCI E/M Modifiers

- Modifier 27
  - Defined as “multiple outpatient E/M encounters on same date”
  - Guidelines/instructions:
    - Applicable to hospital outpatients when there is utilization of hospital resources related to separate E/M encounters performed in multiple outpatient settings on one date of service
    - Does not replace condition code G0
    - Used on subsequent E/M codes when more than one is provided to indicate the E/M is a separate and distinct encounter
    - Should only be needed when same UB-04 revenue code is being used on both E/Ms

NCCI Modifier 27 Case Scenarios

- Patient goes to the emergency department (ED) in the morning for fever and later that day goes back to the ED for a finger fracture
  - How would this be reported?
    - Answer: Bill the first claim for the first ED visit and related charges. Bill the second claim for the second ED visit ONLY (Emergency visit = revenue code 045X plus E/M code) including the condition code G0 and modifier 27. All other charges should be on the first claim.
- Patient presents to the ED in the morning for a fever and later that day goes back for fever
  - What would the claim(s) look like?
    - Answer: Bill one claim since the second visit is related to the first visit. The claim would contain one visit code and incorporate all charges for both visits.

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NCCI Manual 2019 Updates – Chapter 11

- Chapter 11: E/M and Medicine Services
  - New guidance and coding for psychiatric services:

> 2. The psychiatric diagnostic interview examination (CPT codes 90791, 90792), psychological/neuropsychological testing (CPT codes *96136-96146*), *and psychological / neuropsychological evaluation services (CPT codes 96130-96133)* must be distinct services *if reported on the same date of service*. *CPT Manual* instructions permit physicians to integrate other sources of clinical data into the report that is generated for CPT codes *96130-96133*. Since the procedures described by CPT codes *96130-96139* are timed procedures, physicians shall not report time for duplicating information (collection or interpretation) included in the psychiatric diagnostic interview examination and/or psychological/neuropsychological *evaluation services or* test *administration and scoring*. *(CPT codes 96101 and 96118 were deleted January 1, 2019.)*

  - Orthotic and prosthetic training involving multiple practitioners:

> *CPT codes 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes) and 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes) are not separately reportable for the same date of service with physical therapy re-evaluation CPT code 97164 or occupational therapy re-evaluation CPT code 97168 when the two services are performed by a single practitioner or two practitioners of the same specialty. If the two services are performed by two different practitioners of different specialties, the two services may be reported utilizing an NCCI-associated modifier.*

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NCCI Manual 2019 Highlights – Chapter 11

- The following are not new for 2019 but highlight a few “pain points” in Chapter 11: E/M and Medicine Services:
  - Units of service and use of modifier 76 for inhalation treatment:

> An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care.
>
> If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.

  - Reporting modifier 25 with drug administration:

> Under OPPS, hospitals may report drug administration services (CPT codes 96360-96377) and chemotherapy administration services (CPT codes 96401-96425) with facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code.

HCPCS Modifiers

New for 2019

A Few New HCPCS Modifiers for 2019

- Modifier ER
  - Defined as "items and services furnished by a provider-based, off-campus emergency department"
  - A billing modifier required with every claim line for outpatient hospital services furnished in an off-campus, provider-based emergency department, which meets the definition of a "dedicated emergency department" as defined in 42 *Code of Federal Regulations (CFR)* 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations
  - Not applicable to critical access hospitals
  - To read more, go to:

    https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11099.pdf

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A Few New HCPCS Modifiers for 2019 (cont.)

- Modifier G0
  - Defined as "telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke"
  - An informational modifier valid for:
    - All telehealth distant site codes billed with place of service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or
    - Telehealth originating site facility fee, billed with HCPCS code Q3014
  - To read more, go to:

    https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10883.pdf

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A Few New HCPCS Modifiers for 2019 (cont.)

- Modifiers CO and CQ
  - Defined as:
    - CO: "Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant (OTA)"
    - CQ: "Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant (PTA)"
  - Payment modifiers to be used when an OTA or PTA provides more than 10% of the service in preparation for CMS' plans to more completely revamp therapy services in the 2020 Medicare Physician Fee Schedule (MPFS)
  - Should be appended on the same line of service as the respective PT, OT, or SLP therapy modifiers (GP, GO, GN) when applicable

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A Few New HCPCS Modifiers for 2019 (cont.)

- Modifier QQ
  - Defined as "ordering professional consulted a qualified clinical decision support mechanism (CDSM) for this service and the related data was provided to the furnishing professional"
  - A voluntary reporting modifier effective July 1, 2018 that may be:
    - Used when the furnishing professional is aware of the result of the ordering professional's consultation with a CDSM for that patient;
    - Reported on the same claim line as the CPT code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system; and
    - Reported on both the facility and professional claim
  - To read more, go to:
    https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10481.pdf

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Questions & Answers

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We kindly request that they forward it to everyone in your group.

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This concludes today's program.

Please consider participating in our upcoming webinar event:

Strategies for Successful CPT Coding of Lower-Extremity Interventional Radiology
Presented: Tuesday, June 18, 2019 | 1:00–3:30 p.m. Eastern

Visit our website for details on this program:
https://hcmarketplace.com/cpt-coding-strategies

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